

CHAPTER M17

MEDICAID FRAUD AND *NON-FRAUD* RECOVERY

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Appendix 4, page 1 Appendix 4, page 2 was added
TN #DMAS-15	1/1/20	Page 7 Page 8 was added as a runover page.
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2, 4, 6, 7 Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 4 was added.
TN #DMAS-7	1/1/18	Table of Contents, page i Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 3 was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 4. Appendix 1 was deleted Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively.
TN #DMAS-5	7/1/17	Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.
TN #DMAS-4	4/1/17	Pages 4, 5 Pages 6 and 7 are runover pages.
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	Page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	Page 3

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M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency The Department of Medical Assistance Services (DMAS) investigates and accepts referrals regarding fraudulent and non-fraudulent payments made by the Medicaid Program. DMAS has the authority to recover any payment incorrectly made for services received by a Medicaid recipient or former Medicaid recipient. DMAS will attempt to recover these payments from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempt from collection efforts by State or Federal law or regulation.

The DMAS Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS) programs. The RAU recovers overpayments due to recipient fraud, abuse, and overpaid benefits through voluntary repayments and criminal prosecution of recipient fraud.

The Third Party Liability Unit (TPL) at DMAS is responsible for investigating and recovering funds paid by DMAS from recipients' estates, trust accounts, annuities and/or other health insurance policies. This unit performs investigations to find "third party resources" that result when Medicaid pays medical costs that a third party should have paid. Medicaid is always the payer of last resort.

B. Utilization Review The DMAS Recipient Monitoring Unit is responsible for reviewing all Medicaid and FAMIS covered services of recipients who utilize services at a frequency or an amount that is not medically necessary in accordance with utilization guidelines established by the state. Only recipients who are excluded, pursuant to 12VAC30-120-370 B, from receiving care from a managed care organization are reviewed and evaluated.

M1700.200 FRAUD

A. Definitions Fraud is defined as follows:

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2)

Abuse is defined as follows:

Beneficiary practices that result in unnecessary cost to the Medicaid program (42 CFR 455.2)

B. DMAS Authority DMAS has sole authority over cases of suspected Medicaid fraud when eligibility for a public assistance payment is not involved (Medicaid only cases). The local department of social services (LDSS) must refer all Medicaid cases involving suspected fraud to the DMAS Recipient Audit Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the Notice of Recipient Fraud/Non-Fraud (form #DMAS 751R) available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>. The following information must be provided when making a referral:

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- confirmation that ongoing eligibility has been reviewed (in relation to the allegation) with evaluation results attached;
- reason(s) for and estimated period of ineligibility for Medicaid;
- the recipient's name and Medicaid enrollee identification number;
- the recipient's Social Security number;
- applicable Medicaid applications or review forms for the referral/ineligibility period;
- address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;
- relevant covered group, income, resource, and/or asset transfer documentation for the time period in question;
- any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and
- information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.

1. Amount of Loss

There is no fiscal threshold for any case for fraudulent and non-fraudulent erroneous payments made by the Medicaid Program.

In order to determine the amount of the loss of Medicaid funds related to the enrollee's eligibility when LDSS has jurisdiction because of participation in another public assistance program, a Medicaid Claims Request (form #DMAS 750R, available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, must be sent to DMAS to obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e., expedited trial dates. Once the information is received and the agency determines that it will not make a joint criminal prosecution referral, the LDSS must send DMAS the Notice of Recipient Fraud/Non-Fraud. DMAS will determine if administrative non-fraud recovery is appropriate.

2. Recipient Fraud

a. Medical Assistance Only

The LDSS must refer cases of suspected fraud involving only medical assistance to the RAU for investigation using the DMAS 751R form. The LDSS must provide the RAU with the recipient's identifying information, address, and information regarding the circumstances of the suspected fraud. The LDSS is also responsible for reviewing and taking appropriate action for ongoing eligibility or termination of coverage, as appropriate. The RAU will determine the amount of the misspent funds and pursue recovery and/or legal action as appropriate.

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b. Cases in which Medicaid is received with TANF, AG, and other money payment public assistance programs.

The LDSS is responsible for the investigation of suspected fraud involving cases with combined Medicaid and Auxiliary Grant (AG); Medicaid and TANF; and other money payment public assistance programs. The final disposition on all money payment fraud cases shall be communicated to the RAU no later than 5 business days after disposition.

c. Cases in which Medicaid is received with Supplemental Nutrition Assistance Program (SNAP), Energy Assistance, and other non money payment public assistance programs

The LDSS must refer suspected fraud involving Medicaid cases combined with SNAP, Energy Assistance or other non money payment public assistance programs to the RAU using the DMAS 751R form. The local agency shall coordinate cases pending referral for prosecution with the RAU so that Medicaid may take concurrent action.

3. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients shall be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General, and a copy of the referral correspondence shall be sent to the Provider Review Unit at the Department of Medical Assistance Services.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

An individual who has been convicted of Medicaid fraud is ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage shall be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason 014 (42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70).

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

Only the parent/caretaker of a TANF/Medicaid or F&C Medicaid case is ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment made to the caretaker on a child's behalf shall not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.

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3. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY

A. Authority

Any person who, without intent to violate this article, obtains benefits or payments under medical assistance to which he is not entitled shall be liable for any excess benefits or payments received. (COV 32.1-321.2)

B. Recovery of Erroneous Payments

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. Examples of when recovery of expenditures is possible include, but are not limited to:

- eligibility errors due to recipient misunderstanding,
- agency errors,
- medical services received during the appeal process, if the agency's cancellation action is upheld.
- long-term care (LTC) patient pay underpayments totaling \$1,500 or more.

Complete and send the Notice of Recipient LTC Patient Pay Underpayment (form #DMAS752R) located at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to:

Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219

The form can be faxed to 804-452-5472 or emailed to recipientfraud@dmass.virginia.gov.

Underpayments less than \$1,500 can be collected by adjusting the ongoing patient pay (see M1470.900 for patient pay adjustments).

C. Post-eligibility Investigations

The RAU conducts post eligibility investigations. Medicaid nonfinancial and financial requirements are reviewed and applied in accordance to Medicaid policy. See Chapter M02 for the nonfinancial eligibility requirements, and Chapters M06 and M11 for resource requirements.

RAU investigations are based on projected income consistent with the eligibility policies for counting ongoing income referenced in Chapters M04, M07, and M08. Post-eligibility determinations are made using a point-to-point method in which the income estimation period begins with an event that would have triggered a partial review under M1450.100. The end point is the next scheduled renewal that the LDSS actually completed.

D. Uncompensated Asset Transfers

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated

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transfer resulted in a penalty period during which LTC services were received, a referral must be made to the RAU to recover the misspent dollars. RAU staff will contact the recipient or the recipient's authorized representative to pursue recovery.

Section §20-88.02 of the Code of Virginia also allows DMAS to seek recovery from the **transferee** (recipient of the transfer) if the amount of the uncompensated transfer is \$25,000 or more and occurred within 30 months of the individual becoming eligible for or receiving Medicaid LTC services. The transferees may be liable to reimburse Medicaid for expenditures up to the amount of funds spent on the enrollee or the amount of the uncompensated transfer, whichever is less.

E. Recovery of Correctly Paid Funds

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients.

1. Deceased Recipient's Estate

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery may include any Medicaid payments made on his/her behalf. This claim may be waived if there are surviving dependents. (**42 CFR §433.36; Va. Code §32.1-326.1 and 32.1-327**).

Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.

Referrals should be made to DMAS for estate recovery when the deceased recipient is over 55, has no surviving spouse, no children under 21 or a disabled/blind child of any age.

2. Insurance Settlements and Similar Recoveries

Settlements related to personal injuries are a form of third party liability (TPL). When a Medicaid enrollee has received an insurance settlement or similar settlement from a law suit related to a medical condition or injury, DMAS may seek recovery of any amount of medical assistance expended on the enrollee prior to the receipt of the settlement. Generally, the insurance company notifies DMAS of the settlement; however, if an agency discovers that an enrollee received a settlement, the agency shall report it to DMAS. An insurance settlement that is sent directly to a recipient, in his name only, should be reviewed for its impact on the recipient's eligibility.

3. Trusts

Refer trust documents, including irrevocable, discretionary, pooled, and special needs trusts, to DMAS TPL for potential recovery at the time of recipient's (beneficiary's) death. Refer trust documents in all instances in which a Medicaid recipient is a beneficiary of a trust and the trustee refuses to make the assets available for the medical expenses of the recipient. Include a copy of the Medical Assistance Program Consultant's evaluation of the trust with the referral form, if available.

Include in the referral any corrective action that has been or will be taken by the LDSS, as well as the name of the supervisor of the person submitting the form. The supervisor's signature is not required.

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4. Notification to DMAS

Referrals must be made to the Third Party Liability Unit when: a recipient has received funds from a settlement; DSS has received information concerning a recipient being in an accident; DSS has information where a recipient has other third party payers; or the recipient is the beneficiary of a trust. The cases should be referred to DMAS using the Notice to DMAS of Estate Recovery/TPL/Trust Form (DMAS 753R) located at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to make referrals to the TPL unit. The form should be completed and sent to:

Department of Medical Assistance Services
Third Party Liability Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The form may be faxed to 804-786-0729.

M1700.400 RECOVERY RESPONSIBILITIES: LDSS AND DMAS

A. VDSS/LDSS Responsibilities in Loss Prevention Efforts

VDSS Medicaid operates under an interagency agreement with DMAS which lists specific responsibilities of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.

B. LDSS Requirements

LDSS must participate in the identification, tracking, and correction of eligibility errors. LDSS must also determine and review ongoing or current recipient eligibility. **The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud.** LDSS shall:

1. Report Individuals

Report to DMAS RAU every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement such as:

- instances where evidence of fraud may exist;
- errors involving eligibility discovered by the LDSS in which it appears there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
- eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
- cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and
- LTC patient pay underpayments resulting from any cause totaling \$1,500 or more.

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**2. PARIS
Match Data**

The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veteran benefits and enrollment in multiple state's Medicaid programs. Each public assistance report is matched by social security number.

The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Once the evaluation of the match is completed and the case comments are documented, send the **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery, (form #DMAS 754R)** to the DMAS Program Integrity Division, where steps will be conducted to complete the match and Benefit Impact Screen (BIS). Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>.

Complete and send the **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 754R)** located at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to

Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219

The form may be faxed to 804-452-5472 or emailed to recipientfraud@dmass.virginia.gov.

**3. Corrective
Action**

Report to the DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.

**4. Cancel
Coverage**

Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

**5. Incarcerated
Individuals/
Offenders**

The Cover Virginia Incarcerated Unit (CVIU) is responsible for evaluating PARIS matches for offenders whose cases are being held at the CVIU and reporting findings to the RAU as outlined in M1700.400 B.1 above.

C. DMAS Response

The RAU shall send a referral acknowledgement letter to the LDSS worker making the referral. RAU may send out additional communication to the LDSS should additional verifications/documentation be required to complete the investigation.

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D. Recipient Audit Reporting

The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS. The individual may remain anonymous.

- The individual may send an e-mail to recipientfraud@dmas.virginia.gov.
- The individual can call the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

E. Statute of Limitations

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud shall be flagged to ensure that the information is not purged.

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NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

Date: / /

To: **Recipient Audit Unit (RAU)**
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Fax Number: (804) 452-5472
Email: RecipientFraud@dmas.virginia.gov

Case Name: _____

Case Name SSN: _____ **Medicaid Case Number:** _____

Case Address: _____

Is this a Criminal case being presented to your Commonwealth Attorney? ☐ **Yes** ☐ **No**

Has the Case Head been informed a referral is being sent to RAU? ☐ **Yes** ☐ **No**

Check the appropriate box below and give an explanation in the summary section.

☐ **Fraud**
☐ **Agency Error**
☐ **Other**
☐ **Uncompensated Transfer**
☐ **Non-Entitled Receipt of Medicaid**
☐ **Ineligible for Medicaid**
Dates: _____

Ineligible person(s): _____

Explanation summary of referral and any corrective action taken by the agency:

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NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

ATTACH THE FOLLOWING INFORMATION IF AVAILABLE:

- Reason for and estimated period of ineligibility for Medicaid.
- Applicable Medicaid applications or review forms for the referral/ineligibility.
- Any record of communication between the agency and the recipient or recipient's representative, such as case narratives, letters, and notices.
- Information obtained for the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.
- Relevant covered group, income, resource, and/or asset transfer documentation.
- A copy of any Regional Specialist's decision regarding trust that affects eligibility.
- Address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;
- Confirmation that ongoing eligibility has been reviewed in relation to the allegation and the results. This can be addressed in the summary of the referral.

Name of Eligibility Worker:

Telephone Number:

() -

Agency Name: _____

FIPS Code: _____

Address:

Name of Supervisor:

RAU will send acknowledgment of receipt to the referring agency. RAU will contact the agency if any further action is required.

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NOTICE OF RECIPIENT LONG TERM CARE (LTC)
PATIENT PAY UNDERPAYMENT

Date: / /

To: **Recipient Audit Unit**
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Fax Number: (804) 452-5472
Email: RecipientFraud@dmas.virginia.gov

Case Name: _____

Case Name SSN: _____ **Medicaid ID Number:** _____

Case Address: _____

Are funds available to pay the underpayment back? ☐ **Yes** ☐ **No**

Have payments been made directly to the nursing facility? ☐ **Yes** ☐ **No**

LTC Patient Pay Underpayment Breakdown

Month/Year	“Old” Patient Pay Amount	“New” Patient Pay Amount	Underpayment Amount
Total Time Frame:		Total Amount:	

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NOTICE OF RECIPIENT LTC PATIENT PAY UNDERPAYMENT

Explanation for the Underpayment:

THINGS TO REMEMBER:

- All LTC patient pay underpayments totaling \$1,500 or more should be referred to the Recipient Audit Unit (RAU). For Underpayments less than \$1,500, reference M1470.900 for patient pay adjustments.
- Provide a monthly breakdown of the underpayment calculation along with the total underpayment amount. If additional space is needed, please attach your calculations to this form.
- Provide verification of the change that occurred that affected the patient pay. For example, income verification, cancelation of insurance premium.
- Provide pertinent case notes regarding the patient pay and underpayment.

Name of Eligibility Worker: _____

Telephone Number: _____

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Agency Name: _____

FIPS Code: _____

Address: _____

Name of Supervisor: _____

RAU will send acknowledgment of receipt to the referring agency. RAU will contact the agency if any further action is required.

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NOTICE to DMAS of ESTATE RECOVERY/TPL/TRUSTS

DATE: __/__/____

TO:

**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
TPL UNIT
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219
FAX NUMBER: (804) 786-0729**

Case Name: _____

Case Address: _____

Case Name's Social Security Number: _____ - -

Medicaid Case Number: _____ - -

☐ **Estate Recovery** Refer when deceased member is over 55 and has no surviving spouse, child under 21 or a disabled or blind child of any age.

☐ **TPL Recovery** Member has received funds from a settlement. DSS has received information concerning member being in an accident. DSS has information where member has other third party payers.

☐ **Trust** Refer all: Irrevocable, Discretionary, Pooled, and Special Needs Trusts

Explanation Summary of referral:

Describe any corrective action taken by the agency:

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NOTICE to DMAS of ESTATE RECOVERY/TPL/TRUSTS

ATTACH THE FOLLOWING INFORMATION IN THE ORDER LISTED BELOW:

- **Confirmation that ongoing eligibility has been reviewed in relation to allegation and results:**
- **Please attach the required decision from your Regional Specialist on all trust referrals;**
- **Member's Social Security number;**
- **Applicable Medicaid applications or review forms for the referral/ineligibility**
- **Address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;**
- **When reporting health insurance information please include a copy of the insurance card or write in the "Explanation Summary of referral" as much information you can obtain. The policy number, insurance carrier name is most important.**
- **When reporting accident information concerning a Medicaid member, please include date of accident, the name of the attorney representing the member or the liable insurance carrier's name and address.**
- **For Estate recovery please include the address of any property owned by the Medicaid member.**
- **Relevant covered group, income, resource, and/or asset transfer documentation;**
- **Any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and**
- **Information obtained from the agency's investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.**

Name of Eligibility Worker/Medicaid Technician: Telephone Number:

_____ (____) _____ - _____

Agency Name: _____

FIPS Code: ____

Address:

Name of Supervisor:

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PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM (PARIS) NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

Date:

To: Department of Medical Assistance Services
Recipient Audit Unit (RAU)
Fax Number: (804) 452-5472
Email: RecipientFraud@dmass.virginia.gov
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If you fax or email, you do not need to mail a copy of the referral.

Case Name:	
Case Social Security Number:	
VaCMS Number:	
Medicaid Number:	
Case Address:	

☐ **PARIS Interstate**

☐ **PARIS Veterans**

☐ **PARIS Federal**

Match Person(s):		
Date of the PARIS match:		
Date of contact with the other state government agency:		
Individual(s) receiving Medicaid in the other state:		
Individual(s) receiving Veterans or federal benefits:		
Start date and end date of Medicaid from other state:		
Veterans or Federal benefit information:		
Did you verify individual (s) met Virginia residency for ongoing Medicaid coverage?	Yes they met VA residency. <input type="checkbox"/> If yes date of confirmation from individual (s) verifying they are residing in VA:	No they did not meet VA residency. <input type="checkbox"/> If no date VA coverage will be cancelled:
Documentation on file:		

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Name of Eligibility Worker:	Telephone Number:
Agency Name:	FIPS Code:
Address:	Name of Supervisor:

RAU will send acknowledgment of receipt to the referring agency and will be in contact if any further action is required